

Zeppe Wellness
2146 Robinson Street
Regina Saskatchewan
S4T 2P7
Phone: (306) 757-4325
Fax: (306) 522-0745

**AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE
PROFESSIONAL TO ZEPPE WELLNESS CLINIC**

(Please fax this form back with the records)

To: Dr.: _____
(please print)

From: Patient: _____
(please print)

Fax No#: _____

Date of Birth: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

X-Rays _____

Laboratory Results _____

Other _____

On behalf of Julie Zepp Rutledge N.D., I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____

(If patient is under the age of 18 signature of Legal Guardian or Parent is required)

Date: _____

Witness: _____

(Signature) _____

Julie Zepp Rutledge ND License #138